

Chronic Neglect: Indicators and Strategies for Response

A Study Conducted for the Iowa Department of Human Services
by Human Systems and Outcomes, Inc., May 2006

[This document is a summary of the scholarly version of the white paper produced for the Iowa Department of Human Services. The reader should refer to the scholarly version to access the referenced tables and appendix.]

Introduction

Chronic neglect of children in Iowa by some families has tremendous consequences for children, families, state agency staff, local service agencies, communities, and the state. While often given less attention than child abuse, chronic neglect is more prevalent, requires more local and state resources, and results in long-term negative individual, family, and community effects. Some studies suggest that agency representatives should respond as quickly and aggressively to neglect allegations as they do to allegations of physical and sexual abuse as multiple types of maltreatment co-occur and recur.

In 2003, 13,303 cases of child maltreatment were substantiated and 22,761 cases were unsubstantiated in Iowa, and of the substantiated cases, 9,843 or 74 percent of these cases were categorized as child neglect (with an additional 12 percent categorized as medical neglect, psychological maltreatment, or a combination of maltreatment categories).

This paper takes a look at defining and identifying indicators of and strategies for response to chronic neglect through three analyses. First, a review of literature is provided relative to chronic neglect. Second, familial patterns are assessed in a sample of case histories of Iowa chronic neglect families utilizing the *Case Pattern Archetypes in Child Welfare Practice* developed by Human Systems and Outcomes, Inc. Third, interviews with a

sample of child welfare staff were completed to assess their perceptions of familial patterns in chronic neglect families.

Part 1: Review of Literature

Defining Chronic Neglect

Defining child abuse and neglect is difficult, and the construction of clear, reliable, valid and useful definitions is elusive. Lack of social consensus results in state laws and policies that use different definitions, and there is no agreement as to whether definitions should be based on adult characteristics, adult behaviors, child outcomes, environmental context, or some combination.

Typically, child neglect is defined along a continuum of omissions in parental care-taking. Chronic neglect is characterized by its chaotic and unpredictable character, insufficient cognitive stimulation and emotional nurturance for the children, and the long-term involvement of children and families with family support and child protection services.

In Iowa, there is no formal definition for chronic neglect, and child neglect is considered “denial of critical care”, defined in **Iowa Code section 232.68** as “failure on the part of a person responsible for the care of a child to provide for the adequate food, shelter, clothing or other care necessary for the child’s health and welfare when financially able to

do so or when offered financial or other reasonable means to do so.”

Defining chronic neglect is even more difficult. Child maltreatment is detected through a variety of mechanisms and systems, and “encounters” vary by their means of collection and reporting. There are also differences in the length of time that individual and family records are maintained and followed. The result is that the prevalence of child neglect recurrence is widely variable, ranging from less than 5 percent in some states to over 66 percent in others. Some argue that many neglect cases are screened out due to the difficulty in describing or detecting neglect and concerns regarding various cultural differences. Others suggest that when resources are limited, definitions of neglect and responses to it reflect tolerance standards.

Categorizing families as chronic neglect families can also be misleading. Although there may be many more reports of neglect, typically scattered among the neglect findings are reports of physical and sexual abuse. Indeed, the type of initial child maltreatment report (abuse or neglect) is not predictive of subsequent report types; variability, rather than similarity, is the norm. The more chronic the family history is found to be, the more reports of neglect. Families shift back and forth between abuse and neglect. Although most findings are related to unmet basic needs (lack of food, appropriate clothing, heat, shelter, sanitary living conditions) and medical needs, it is important to recognize the potential and likelihood for abuse to occur in neglectful families.

Effects of Chronic Neglect on Children, Families, and Communities

The costs of chronic neglect are high in terms of developmental, experiential, and financial

effects on children, families, communities, and government entities in the short and long term. Neglect issues are serious; children can die. Nationwide in 2002, 38 percent of child maltreatment fatalities were associated with neglect alone. In addition, there is some evidence that neglect results in greater cognitive and academic deficits than abuse. Families repeat cycles of dysfunction over many generations with a wide range of effects on communities. Local and state government entities and their organizational partners expend tremendous resources on neglect cases. In a study of 8,748 children in out-of-home care, two-thirds were in foster care due to neglect rather than abuse, suggesting neglected children have lower rates of reunification. The average time children of chronic neglect are placed out of home is 913 days. One-half of all child welfare expenditures are spent on chronic neglect cases with a fifth of all families responsible for one-half of the spending, averaging \$13,000 per year over a five year period.

Effects on Children

Although it is difficult to determine the differences in effect between abuse and neglect due to the movement of families between these two categories, the co-occurrence of abuse with neglect, and the research practice of including children of both abuse and neglect as one group, chronic neglect is associated with long-term detrimental effects in children. Adverse effects may be of a physical, cognitive and language, and/or social and emotional nature. Victims are often very young, may be born prematurely, and/or drug dependent. Children referred for child welfare services have high developmental and behavioral needs regardless of whether they remain with their parents or are placed in out-of-home care.

Physical health consequences can include impaired brain development. Brain development or learning is a process of creating, strengthening, and discarding connections among neurons, and growth in each region of the brain is largely dependent on stimulation. If appropriate stimulation is not received, neural pathways developed in anticipation of these experiences may be discarded and the development of related functions will not occur as expected. Prolonged, severe, or unpredictable stress sensitizes neural pathways and over-develops certain regions of the brain involved in anxiety and fear responses and under-develops other regions of the brain.

The result may be dysfunctional physiological changes in both the brain and body—sending cues to the mind and affecting what it senses, feels, and perceives and overly conditioning and sensitizing the mind to react to life threats and perceive threats where none exist. Manifestations may include persistent fear response (leading to anxiety, depression, and difficulty forming attachments), hyperarousal (leading to hyperactivity, anxiety, impulsivity, sleep disturbances), dissociation, disrupted attachments (leading to impaired social cognition or understanding of the emotions of others), increased vulnerability to post-traumatic stress disorder, developmental delays (including language), sensory integration disorders (associated with severely neglected children deprived of sensory stimulation). Malnutrition is also associated with stunted brain growth. For example, iron deficiency can result in cognitive and motor delays, and protein deficiency can result in cognitive and motor delays and impulsive behavior.

Poor health outcomes are all too common. In a study of abused and neglected children in foster care, children weighed significantly less, were shorter in stature, required more

medical sub-specialty care, had higher incidences of developmental delays, and were diagnosed with more chronic medical conditions than the general child population. Furthermore, several studies have found relationships between household dysfunction and long-term health problems such as heart disease, cancer, chronic lung disease, and liver disease.

Cognitive and language deficits are also more prevalent in children of neglect than the general population. Higher incidences of cognitive delays and impairments and lower levels of language development and verbal ability are found. Poor academic performance is not uncommon and may be related to frequent placement moves.

Psychological effects are often manifested as high-risk behaviors (e.g., depression and anxiety may increase the likelihood that an individual will smoke, abuse alcohol and drugs, engage in risky sexual activities, or overeat), and high risk behaviors can lead to long-term physical health problems (e.g., sexually transmitted diseases, cancer, and obesity). Other social and emotional consequences include poor mental and emotional health as evidenced by panic disorders, dissociative disorders, attention deficit/hyperactivity disorder, post-traumatic stress disorder, and attachment disorders. A Washington state study of abused and neglected children in protective service case-loads found that almost three-quarters of the children were indistinguishable from children in the state's most intensive, residential mental health treatment programs. Furthermore, attachment difficulties can lead to difficulties in forming relationships during adulthood.

As evidence of the long-term effects of child maltreatment, youth exiting the child welfare system were found to be faring worse than

their same-age peers, experiencing educational deficits, lower levels of employment, and lower salaries. Although one-third received some behavioral and mental health supports, many more needs were not addressed and few received education assistance despite lots of placement-associated school disruptions and moves. Few received independent living skills training. Large numbers were continuing to struggle with health and mental health problems, and too many were involved with the criminal justice system and/or had children of their own for whom they could not provide a home.

Family Effects

In addition to the obvious disruption of family relationships, chronic neglect results in traumatic effects—physical, cognitive, and psychological—for the entire family. Indeed, parents and families are often repeating earlier traumas in the process of neglecting their children.

Numerous studies have found that families that maltreat their children are more likely to have been child victims themselves. Trauma victims are conditioned to earlier experiences, and the emotions and physical symptoms of past traumas often emerge unexpectedly and unconsciously. Scaer argues that the way someone acts, looks, and moves may be based more on childhood trauma than on a current event. Trauma can affect appearance, posture, and health and plays a role in causing or triggering most if not all mental illness.

Neglectful families also experience stressful home environments on a day-to-day basis. They report higher frequencies of conflict and view their lives as more chaotic than typical families. Their relationships and interactions interfere with household routines, rituals, and responsibilities and are often volatile.

Movement of children in and out of the home is associated with high levels of stress for all family members.

Community Effects

Chronic neglect has a tremendous impact on health and mental health organizations, law enforcement, judicial and correctional systems, and social service agencies. In addition to the extraordinary costs of services, there are workload problems, jail crowding issues, and management concerns.

Societal consequences include the direct costs of maintaining child welfare, judicial, law enforcement, health and mental health systems, estimated to be \$24 billion per year by Prevent Child Abuse America. The indirect costs associated with mental illness, substance abuse, criminal activity, domestic violence, loss of productivity due to unemployment and underemployment, costs of special education services, and increased use of health care systems is estimated at \$69 billion per year.

Risk Factors Associated with Chronic Neglect

In order to intervene as early and quickly as possible, it is important to know those risk factors that are associated with chronic neglect. Child, family, and community risk factors are noted in this section. It is imperative to note, however, that the identified factors have not been determined to be causal. In other words, the presence of one or more risk factors does not indicate that child neglect will occur or has occurred.

Indeed, while some risk assessment models have been successful in predicting child maltreatment, many others have a great deal

of variability. Risk factors should be used in conjunction with education, training, thorough assessment, and experience to make professional and practice decisions.

Child Risk Factors

Child characteristics that are linked to heightened care demands are associated with increased risk of child maltreatment, including neglect. These include low birth weight, health problems, developmental delays, and disabilities. Younger children, particularly children under the age of four, are at increased risk of maltreatment, including recurrent neglect. Children with social and emotional challenges are also at increased risk. Risk for maltreatment and recurrence is greater for children with difficult temperaments, conduct problems, and severe behavior problems. Behavior issues are often associated with multiple placement moves and are associated with less likelihood of family reunification and greater changes of recurrence.

In addition, children with prior reports are more likely to experience maltreatment. In a multi-state study, children who experienced neglect were 27 percent more likely to experience recurrence. Another multi-state study found that cases involving multiple maltreatment types were 15 percent more likely to recur, and subsequent allegations often involve a different type of maltreatment.

Family Risk Factors

Socio-economic indicators, family constellation, and mental health issues are family factors associated with chronic neglect. In many chronic neglect families, combinations of these factors co-occur. Serious mental illness is common among substance-abusing

women, as is domestic violence, HIV/AIDS, poverty, and inadequate housing. Over one-third of females with drug use problems have experienced a major depressive episode in the past year, and 45 percent have experienced at least one mental health problem.

Demographic Factors

Poverty is associated with incidences of child neglect. Although the great majority of low-income families do not neglect their children, the stresses of poverty make it harder for these families to deal with the demands of parenting, particularly in combination with other child, family, and community hardships. Recurrence rates are also higher in rural areas, among parents with low education levels, and in families with inadequate housing.

Child neglect is more prevalent among families headed by a single parent or by young parents and in larger families. Mothers with less than a high school education, that did not receive adequate prenatal care, that are younger than 20 or older than 30, and that have health problems are also at increased risk for child neglect. In general, child abuse reports increase and child neglect reports decrease when men enter mother-only families. Conversely, when males disappear from reported families, increases in child neglect and decreases in child abuse reports are found.

Mental Health Factors

Numerous mental health issues impact the prevalence of child neglect. Low self-esteem and high levels of stress are associated with increased incidence of child neglect. Recurrence is associated with lack of resolution of parent-child conflict and ambivalence

regarding the parental role and family reunification. Adults who are low functioning with mild mental disabilities are at greater risk for chronic neglect. Levels of social support also impact maltreatment rates. Low levels of social support are associated with increased risk, and parents with more support from extended family members are less likely to have children reenter care. In a study of social support networks of low-income, single African American mothers identified as neglectful, researchers found that the mothers approached helping relationships as what others could do for them, lacked reciprocity, and had lots of conflict and distrust. Depression and other types of mental illness are also related to the incidence of chronic child neglect.

Substance Abuse Factors

Most studies find that parental substance abuse is a contributing factor for between one-third and two-thirds of children in the child welfare system, and 80 percent of states reported that substance abuse and poverty are the top two issues contributing to child abuse and neglect. Nine percent of the children in this country live with at least one parent who abuses alcohol or other drugs, with alcohol abuse being most prevalent, and children with substance-abusing parents are four times more likely to be neglected. As a group, parents with substance abuse problems have somewhat less education, are somewhat less likely to be employed full time, are much less likely to be married and much more likely to participate in welfare programs. African American women have higher rates of illicit drug use, but there are many more white women who use illicit drugs than there are minority women. Substance abuse rates are highest among Native Americans. The Indian Child Welfare Association estimates that 90 percent of

Indian child welfare neglect cases involve families with substance abuse problems.

In general, substance abuse is more likely to be an issue in reports regarding younger children, particularly infants, than older children, and is a factor in child neglect more often than child abuse. Families with substance abuse problems are more likely to be from a neighborhood with safety problems, to be on welfare, and their children are more likely to be in foster care and have been there an average of six months or longer. Once identified, children from substance abuse families reenter the system more often than children in other maltreating families (30 percent versus 17 percent) and are less likely to have left foster care within a year (55 percent versus 70 percent).

According to treatment data collected by the Substance Abuse and Mental Health Services Administration, methamphetamine abuse and addiction is increasing, and Iowa is among the states with the highest rate of addiction (with more than 50 methamphetamine users in drug treatment programs per 100,000 state residents). Children of methamphetamine addicts are at increased risk for endangerment due to exposure to toxic combustible chemicals, being left without supervision or care, and family members and others perpetrating physical and/or sexual abuse while under the influence. Methamphetamine is a powerfully addictive and easily made synthetic stimulant that causes the brain to release a surge of dopamine. Its effects last longer (typically six to eight hours) and the drug stays in the body longer than other stimulants.

Methamphetamine has dramatic short-term effects, including increased activity and attention, decreased fatigue and appetite, increased respiration, feelings of well-being, and hyperthermia. High doses can elevate

body temperature to dangerous, even fatal, levels. Chronic and long-term abuse can result in loss of skin elasticity and luster, tooth decay (due to poor diet, tooth grinding, and poor oral hygiene), violent behavior, confusion, insomnia, psychosis (including paranoia, auditory hallucinations, mood disturbances, repetitive motor activity, and delusions), heart and blood vessel damage, and stroke. Increased rates of HIV and hepatitis B and C transmission are also found among methamphetamine users due to sharing injection equipment and increased high risk sexual behaviors.

There are risks associated with drug abuse that can persist despite ending use. Methamphetamine addicts who commit to drug abuse treatment are faced with difficult symptoms including depression, anxiety, fatigue, paranoia, aggression, and intensive cravings for the drug. As much as 50 percent of the dopamine-producing cells in the brain can be damaged with prolonged exposure to relatively low levels of the drug. Serotonin-containing nerve cells can be even more extremely damaged. Although dopamine receptors can grow back over time once the drug abuse ends, there is evidence that there can be permanent brain damage resulting in declines in reasoning, judgment, and motor skills.

Substance abuse has profound effects on parental disciplinary choices and child-rearing styles. Parents who abuse substances are less likely to function effectively in the parental role due to physical and mental impairments that occur while under the influence and the time utilized seeking out and using alcohol and other drugs. In addition, their expenditures for substances reduce household resources, and they are at increased risk of unemployment. As a result, children of substance-abusing parents are more likely to have poorer physical, intellec-

tual, social, and emotional outcomes and are at greater risk of developing substance abuse problems themselves.

Domestic Violence Factors

Domestic violence is another mental health issue associated with chronic child neglect that has profound effects on families. Research indicates that in 30 to 60 percent of the families where either domestic violence or child maltreatment occurs, it is likely that both forms of abuse exist. A national survey found that 50 percent of men who frequently assaulted their wives also frequently abused their children, and one study found that women who were victims of domestic violence were eight times more likely to hurt their children. Alcohol and illicit drugs factor in and are a precursor to domestic violence with 25 to 50 percent of domestic violence incidents involving alcohol. Substance abuse typically increases the severity and frequency of violence. For children, witnessing or being exposed to domestic violence can produce a range of short- and long-term social, emotional, behavioral, and cognitive problems. Eighty to 90 percent of children in homes where domestic violence occurs can provide detailed accounts of violence.

Domestic violence negatively impacts parenting behaviors. Common behaviors among domestic violence perpetrators that have harmful effects on children include authoritarianism, lack of involvement, undermining the victim, self-centeredness, and manipulation. Parents suffering from abuse exhibit higher levels of stress, influencing their relationships with and responses to their children. They may be preoccupied with avoiding physical attacks and coping with violence and experience challenges in efforts to provide safety, support, and nurturance to children. At times, they may be emotionally and physically

unavailable to children due to injuries, emotional exhaustion, or depression. However, many victims are supportive, nurturing parents mediating the impact of violence in the family.

Community Risk Factors

The environments in which families live, work, go to school, and play influence their well-being and functioning. Neighborhoods with residential turnover, poverty, significant unemployment, violence, lack of accessibility, and lack of social relationships and trust between neighbors are high-risk environments for families. Communities with a military presence and where natural disasters or crises have occurred also have higher rates of child neglect.

In addition, the availability and accessibility of community services impacts risks for families. When services are difficult to find or are uncoordinated, families suffer. Barriers to effective service provision include the different philosophies and priorities of different systems. For example, child welfare agencies tend to focus attention on the needs of children, and domestic violence agencies focus their resources on the victim, most often a mother. The court system focuses on community safety and rehabilitation and has moved toward case specialization (juvenile courts, family courts, etc.) resulting in child abuse and neglect cases being heard in one type of court and domestic violence cases in another court. Even though child maltreatment and domestic violence may (and often do) co-exist within families, communities typically address the issues separately, and optimal outcomes for families may be sacrificed.

Mediating Factors that Foster Capacity for Parents and Stability for Homes

Not all children who are neglected will experience long-term consequences. Outcomes vary widely and are affected by a variety of factors. Characteristics of the child, family, and community can support resiliency. Identifying family strengths and shoring up community resources are important components of case planning and implementation.

Child characteristics that positively impact child neglect include the child's age, health, and developmental status when the neglect occurred as well as their personality traits. Individual characteristics such as optimism, self-esteem, intelligence, social skills, creativity, humor, and independence may serve as individual protective factors. Secure attachment to at least one person, even if only seeing that person occasionally, is related to children maintaining the concept of relatedness and a sense of "unconditional positive regard."

Placement stability enables secure attachments to develop and remains a positive factor for young adults in the child welfare system. Youth that are allowed to remain under foster care beyond age 18 appear to have significant advantages as they transition to adulthood. They are more likely to receive independent living assistance, complete more education, and access health and mental health services. They are less likely to become pregnant, suffer economic hardship, and become involved in the criminal justice system.

For families at risk, access to social support appears to be a strong mediating factor. Although income status is associated with child maltreatment, poverty does not make a family neglectful. Social support, both informal family and friend networks and

formal supports, appears to an important mediating factor intervening between poverty and maltreatment. In addition, maternal/infant bonding plays a powerful role in the development of resilience to threat and stress throughout the lifespan. Other protective factors include employment and economic security, good health, educational attainment, self-esteem, and social skills.

Community well-being, including neighborhood safety and access to health care, may be other protective factors. In socially rich environments, needs and resources tend to balance as individuals can afford to give and share with neighbors. In socially impoverished environments, however, individuals tend to operate in a “scarcity” economy. Interactions are more likely to be developmentally destructive with negative effects on cognitive function, physical health, and/or emotional well-being. Studies suggest that neighborhoods should be screened to identify high and low risk areas. Low risk area parents assume more direct responsibility for child care, exchange child supervision with neighbors, and rate their neighborhoods as better places to raise children. Parents in high risk areas are less self-sufficient, participate in less reciprocal exchange, and do not view their neighborhoods as good places to raise their children. Strong support systems are most needed but are less available in high risk areas.

Implications for Practice Models

Solid empirical research evidence on child welfare practice remains in the early stages of development as research in this field has often been of a low priority. All too often practice guidelines are not evidence based, substantiated by strong methodology. “Evidence-based practice” is defined as a combination of best research evidence, best

clinical experience, and consistent with family values.

Certain practice strategies are more successful than others. Comprehensive family assessment, family team planning, integrated and comprehensive service delivery, concurrent planning, support network building, and safety planning are practice strategies linked to positive outcomes.

Early and Ongoing Comprehensive Family Assessment

There is growing evidence of the importance of accurate, early and ongoing comprehensive family assessments. In a case study involving young adults who had experienced child welfare services and out-of-home placements in Minnesota and were now living independently, researchers found that reunification services often pushed for returning children to their parents without a clear plan for addressing the original issues (e.g., social isolation, parental mental illness, substance abuse). Reduced rates of recurrence are associated with risk assessment protocols and planning tools and family assessments completed early in the provision of services. Assessments of individual family member strengths and needs are more accurate and effective in developing a successful case strategy.

Although the focus of child welfare services is the children, services tend to concentrate on safety issues and too often the developmental and treatment needs of children are overlooked. Children referred for child welfare services have high developmental and behavioral needs regardless of whether they remain with their parents or are placed in out-of-home care. Few children, however, receive services to address developmental and behavioral needs (only 22.7 percent in

one study), and children that remain with their parents and children under three years of age are even less likely to receive needed services. In order for children to overcome the trauma and injuries caused by chronic neglect, treatment and supports are imperative. Caseworkers and other team members with a good understanding of child development are more likely to facilitate comprehensive assessments and services that attend to the developmental and adaptive functioning of the child.

As evidence of the importance of ongoing screening and assessment, studies of children in foster care have found that they are at greater risk for compromised developmental and health problems, delayed cognitive development, lower academic functioning, higher rates of depression, poorer social skills, and more behavior problems. Although it is difficult to distinguish the effects of maltreatment before entering foster care and the negative effects of foster care, there is evidence that foster care can negatively impact development, and placement instability, in particular, is associated with negative developmental outcomes for children. In a large study of placement disruption, unmet behavioral health needs were by far the biggest cause of placement movement. Children in stable placements (kinship care settings had the fewest moves) were more likely to receive therapy, had higher rates of school achievement, and were rated as less delinquent. These findings underscore the importance of ongoing screening and assessment and careful selection of foster homes.

Screening and assessment should be comprehensive, acknowledging the multiple risks that often co-occur in chronic neglect families. Assessment for domestic violence and substance abuse should occur on every child maltreatment report, and routine screening for these risks should occur at every phase of

the child protection process. Screening efforts should also extend beyond surveying family members to include criminal records checks, case file reviews for prior allegations, and local police department contacts to inquire about domestic violence-related service calls. In addition, children need continued monitoring in order to intervene with manifestations of the effects of chronic neglect, which can include increased aggression, depression, and risky behaviors (e.g., substance abuse, high risk sexual activities, and criminal behaviors).

Family Team Planning and Decision Making

Family team planning and decision making is a practice strategy that brings together a wide range of formal and informal support resources for the family with the goal of providing safety and stability for the children. Target family members work with child welfare staff, extended family members, community service providers, and other neighborhood representatives to make critical decisions about meeting the needs of the children and family. Team members are involved in assessing the strengths and needs of the family, developing specific and achievable safety plans, designing in-home and out-of-home services, and making decisions regarding removal and change of placement or reunification. Essential to the team decision-making process is a respect for active family involvement, use of a strengths-based assessment, and a commitment to teamwork. This model requires skilled and experienced facilitators to help the team reach consensus. It also identifies and involves family and community members that can serve as long-term support networks for the family.

Based on review of a variety of family team planning and decision-making models, the following components have been identified

as essential to success:

- Supervisory support—Commitment and support by public agency leadership to efforts that ensure families are respectfully engaged and included in decision making
- Written policies and procedures—Development of policies and procedures that define how, when, and where family meetings will be held, including partnership forms
- Comprehensive curriculum and training—Skill development opportunities for coordinators, supervisors, facilitators, workers, and partners
- Quality assurance process—Mechanisms to ensure consistent application of the practice model and to assess the effectiveness of the model.

Additional findings relative to the family team planning and decision-making model indicate that the development of practice alliances across service sectors can increase the likelihood of successful case resolutions. Relationships and alliances built between child welfare, domestic violence, mental health, early intervention, substance abuse treatment and prevention, and court system representatives can help expand services and provide better supports for families at risk. In addition, reconvening the same team provides consistency for families and helps to insure that information is not lost.

Integrated and Comprehensive Service Delivery

For many families in the child welfare system, problems are multiple and interrelated. Pervasive and persistent poverty is associated with increases in depression. Depression may

result in attempts to self-medicate, leading to substance abuse and addiction. The effects of substance abuse may include hyper-arousal, leading to family violence. Services, therefore, must be coordinated and comprehensive. Providing medications for depression without addressing underlying issues is unlikely to resolve the source of the depression and the consequences for children.

Integrated and comprehensive service delivery is a process designed to address multiple family needs and eliminate fragmentation of services. For families, it means that services to address multiple needs can be accessed, although not necessarily provided, through a single entry point. Families can enter the system through any number of doors, and any door results in a thorough screening and assessment of family needs and assistance to access needed services.

Integrating child welfare, education, economic supports, substance abuse, mental health, domestic violence, and other family service options requires action at multiple system levels. At the legislative level, policy decisions can influence the coordination of services by creating mechanisms for coordinated agency structures (integrating multiple child and family services under one agency structure), cross-agency communication, integrated service application processes and forms, blended funding, and fiscal flexibility. At the agency level, policy decisions and practice standards can increase the likelihood of integrated service delivery through shared training, joint case planning, wraparound services, common intake and assessment processes, and shared support services. On the front-line, service providers can facilitate service integration by addressing family needs holistically and creating local mechanisms for case coordination and communication.

Integrated Mental Health Services with a Focus on Past Trauma

Mental health professionals and researchers are finding that trauma is a central experience of psychiatric disorders and a large percentage of adults and children in human service systems have experienced severe trauma at some point in their lives. In particular, childhood traumatic events can have a significant impact over the lifespan.

The Substance Abuse and Mental Health Services Administration (SAMHSA) conducted a nine-site study on co-occurring disorders and violence and found that integrated mental health and substance abuse services with a

focus on trauma-based treatment can be effective. Focusing on trauma enables individuals to talk about “what happened to them” rather than “what’s wrong with them” and is more likely to communicate a culture of respect and a climate for healing and change. In recognition of the role of trauma in mental illness and that all mental illnesses are treatable, new goals have been developed for the mental health system by the President’s New Freedom Commission. One of the goals recognizes the new knowledge base and treatment developments that enable recovery for all individuals. Another goal, transformation of all service systems, addresses the needed integration of services.

Integrated Substance Abuse Treatment with a Focus on the Needs of Children

Substance abuse presents major challenges for the child welfare field. Addictions to alcohol and other drugs tend to be chronic, relapsing disorders that require long-term recovery. At the same time, children have immediate and critical needs for safe, stable, and nurturing homes. The absence of these conditions can and often does have long-term, negative consequences. In recognition of the needs of children, the Adoption and Safe Families Act emphasizes timely decision making, requiring permanency decisions within a 12-month timeline and requiring agencies to move to terminate parental rights once a child has been in foster care for 15 of the previous 22 months unless there are compelling reasons not to terminate.

Child welfare professionals can make these difficult decisions with integrity and confidence if the following conditions are met: treatment programs are available and accessible and include parent-child services; thorough and ongoing screening and assessment is provided for all family members;

Effects of Violence and Trauma

- Neurological Damage, including
 - Impaired memory
 - Sleep problems
 - Anxiety
 - Panic reactions
 - Depression
 - Disrupted neuro-development
- Adoption of Health Risk Behaviors, including
 - Smoking
 - Obesity
 - Physical inactivity
 - Alcoholism
 - Drug abuse
 - Risky sexual activities
 - Self-injury
 - Eating disorders
- Health and Behavior Problems, including:
 - Ischemic heart disease
 - Cancer
 - Chronic lung disease
 - Asthma
 - Liver disease
 - Skeletal fractures
 - HIV / AIDS
 - Homelessness
 - Delinquency
 - Re-victimization
 - Violence and criminal activity

substance abuse professionals are active members of the family team process and collaborate to establish joint case goals; relapse and safety planning is addressed in family team meetings; and concurrent planning begins as soon as the case is opened. Studies have found associations between improved treatment outcomes (including longer treatment stays and reduced frequency of relapse) and the provision of child development, health care, and other services to children of substance abusers.

For many families, service providers, and communities, these conditions do not exist. There is a great gap between substance abuse treatment needs and available services. It is estimated that only 30 to 50 percent of families with substance abuse problems receive treatment. Many programs create barriers to attendance by not allowing women to come into treatment with their children. Frequently, services for children, such as therapeutic child care, children's skill training and substance abuse education, and parent training and support services are not available.

Successful substance abuse programs collaborate with child welfare professionals, developing joint case goals. Innovative approaches include focusing on early identification of at-risk families in substance abuse programs to reduce the number of maltreated children; stationing addiction counselors in child welfare offices; giving mothers involved in the child welfare system priority access to substance abuse treatment; developing or modifying dependency drug courts to ensure treatment access and therapeutic monitoring of compliance with court orders; and developing cross-system partnerships to ensure coordinated services, funding, and training. Using child protective services involvement as leverage for substance abuse treatment has also proved effective, particularly when families are involved in developing intervention

plans and receive clear disclosure regarding lack of participation or progress and resulting consequences.

Integrated Early Education and Care Services

Given the research evidence on the importance of the early years to an individual's life-long well-being, early childhood professionals have advocated for multiple supports for families with young children. High quality early education and care can be a positive factor in all children's development, but it is particularly beneficial for children in high risk environments. Short-term benefits include less anxiety, more secure attachments with caregivers, less hostility, more positive social interactions with peers, and improved performance on measures of school readiness, cognition, and language. Improved academic and social skills and fewer special education placements, grade retentions, and behavior problems are among the long-term benefits.

Therapeutic child care emerges as one of the strongest evidence-based practices associated with positive outcomes for maltreated children. For many children involved with protective services, early childhood programs provide a safe and positive place to be for a majority of the day. High quality early education and care provides a wide variety of services in addition to stimulating and nurturing environments for children. It connects children and their families to health services, family support programs, and other community services. Screening and assessment occurs on an ongoing basis. Opportunities for parent-child interactions, parent involvement, and parenting education are provided.

Unfortunately, high quality is not the norm in early education and care programs. Most early childhood environments are mediocre

at best and an alarming percentage (up to 35 percent for infant care settings) are of poor quality that places children's health, safety, and development in jeopardy. These nationwide findings underscore the importance of partnerships across service agencies focused on improving all services and systems that provide assistance to families in need. Efforts and markers of high quality are associated with established national (e.g., Head Start and Early Head Start Performance Standards and national accrediting bodies) and state early childhood standards (e.g., state performance standards, quality rating systems), accreditation, and quality improvement initiatives (e.g., collaborations between state and local entities and foundation funders).

Concurrent Planning

Caseworkers are required to make difficult placement decisions for children. They must carefully balance the safety and developmental needs of children and societal values regarding families. Concurrent planning seeks to eliminate delays in attaining permanent family placements for children in the foster care system and involves considering all reasonable options for placement at the earliest possible point following entry to foster care. Although the primary plan may be reunification with the child's family of origin, in concurrent planning, an alternative permanency goal is pursued at the same time.

Based on a 12-state study of foster care data by Chapin Hall, rates of placement outside the home, reunification, and reentry in Iowa differed from state averages. Although younger children were approximately twice as likely to enter foster or kinship care as are older children in other states, older children were more likely to enter care than were younger children in Iowa. Iowa also had one of the lowest median first placement duration

Guiding Principles for Concurrent Planning

- Philosophical and resource support within child welfare agencies, service providers, and other related professionals
- Cooperation and preparation of the judicial system
- Early and aggressive efforts to identify all reasonable permanency options for children
- Engagement of families in collaborative planning and decision making for their child's permanency plan
- Interactions with families based on respect, honesty, and openness

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averages at three months compared to other states. Over 60 percent of discharges from placement were to reunification with the family in Iowa (the average among the 12 states in the study was 48 percent). Iowa also had the highest reentry rate as a percent of entries at 38 percent. These findings suggest that placement decision practices may benefit from a careful review of policies affecting case closure and concurrent planning practices and policies.

Based on final reports from the Federal Child and Family Services Reviews, concurrent planning is linked to positive results in at least 11 states, including reduced time to permanency (particularly for younger children) and establishing appropriate permanency goals. There is growing evidence that openness and direct communication in concurrent planning leads to more voluntary relinquishments and open adoptions. Other concurrent planning factors that were associated with permanency included caseworker consistency (a single change during the year reduced likelihood of permanency by 52 percent), fewer placements (each placement reduced odds of permanency by 32 percent), ineligibility for Title IV-E assis-

Successful Concurrent Planning Strategies

A comparison group study of the Colorado Expedited Permanency Planning process identified strategies associated with positive outcomes. One such strategy was the development of procedures and resources that allowed “front loading” of services. Counties were allocated up to \$5,000 per family immediately following a child’s entry to foster care. These funds were available to family teams to purchase specific services that they identified as essential to the permanency plan, such as substance abuse or mental health evaluation and treatment. Within one year, rates of permanency attainment ranged from 84 to 85 percent for treatment groups to 22 to 32 percent for non-treatment groups. The Expedited Permanency Planning process was expanded to all counties in 2001, and in a December 2003 report, 82 percent of children served by the program attained permanency within one year.

National Clearinghouse on Child Abuse and Neglect Information, 2005

tance (families living in extreme poverty were 90 percent less likely to achieve permanency in 12 months), substance abuse (substance abuse increased the likelihood of permanency by 23 percent), and more days of parental visitation per week (each day of visitation tripled the odds of permanency).

Effective concurrent planning includes:

- Individualized assessment and intensive, time-limited work with birth families targeting the problems that necessitated foster care placement
- Full, documented disclosure with birth parents of problems, changes, possible consequences, and timeframes
- Early aggressive search for birth family resources for achieving permanency
- Early identification and consideration of all permanency options
- Frequent and constructive use of parent-child visitation as part of reunification efforts
- Early use of foster/adoptive or kinship placements

- Involvement of foster/adoptive and kinship caregivers in teaching and skill-building with parents

Concurrent planning requires identification of partners and a commitment to work together. Barriers to multiple systems working together include poor communication, lack of coordination, lack of role clarity across systems, lack of early and accurate assessment of child and birth parent needs, and lack of involvement of mental health, substance abuse, and domestic violence service providers. States are also exploring and implementing foster to adopt policies in order to facilitate improved pathways to permanency for children. Flexible funding and use of fiscal incentives for service providers is associated with moving children more quickly toward permanence.

Support Network Building

Informal and formal support networks provide formidable protection for families at risk. Typically, services for chronic neglect families are of a short-term nature and primarily address the financial needs of the family. Although there is growing evidence and use of beneficial home-visiting and

family support services, their use is usually time limited. Appropriately intensive and long-term services are often lacking despite increasing evidence that post-placement services of less than three months are ineffective in ending cycles of chronic neglect. When services are terminated, families without strong support networks have to cope on their own, and in order to receive additional services, must have a crisis that results in another report being filed. In order to break the cycle, evidence suggests that comprehensive, intensive, and long-term services are required, and support networks are the most cost effective long-term support mechanism.

Building social support networks requires prioritization and commitment on the part of caseworkers and supervisory staff. It requires engaging extended family, service providers, and the community. And, the family team process is an important component of support network building. Opportunities for neighborhood and community partners to collaborate on a regular basis as well as forming local decision-making bodies that engage all stakeholders are associated with better outcomes for families.

There are also process strategies that are associated with developing better support networks for families. Agencies and programs that embrace acceptance of a family empowerment approach, assisting families to develop goals and steps to meet their goals, report more favorable outcomes. Other effective strategies include:

- Using multidisciplinary teams
- Assigning cases geographically so that workers develop a better understanding of neighborhood formal and informal supports
- Ongoing staff training
- Reconvening the same team to help ensure family information is not lost and families are spared repetitive discussions
- Frequent visits between caseworkers and parents

The role of the caseworker as a source of support cannot be underestimated. The relationship between the caseworker and the family affects the case outcome, and there is a high level of evidence that caseworker attitude and training influence placement stability. Families respond most effectively to staff they believe are committed to their well-being. Poor working conditions, high turnover rates, heavy caseloads, low salaries, external decision making, lack of formal social work education, and concerns about staff safety affect staff attitudes and are related to less effective services.

Relapse and Safety Planning

Safety planning results in an individualized plan developed to reduce the immediate and long-term risks faced by a family. It is particularly important for families with substance abuse, mental illness, cognitive impairments, and domestic violence issues—conditions that often result in cycles of adequate and inadequate family functioning. Safety planning should begin at assessment and continue throughout the case. Strategies that reduce risk of physical violence and harm and enhance protection should be included in the plan. Other barriers to safety such as income, housing, health care, child care, and education should also be considered.

Safety planning should be addressed in the family team process. Informal and formal support networks are essential to ensuring child and family safety during relapses and crises. As appropriate to their age, children

should also be included in developing safety plans. Caseworkers and team members need to carefully consider and safeguard information and confidentiality issues when developing these plans.

Part 2: Analysis of Iowa Chronic Neglect Case Histories

A second analysis of chronic neglect was completed utilizing 35 repeat neglect families in Iowa. Familial patterns were assessed utilizing the *Case Pattern Archetypes in Child Welfare Practice* developed by Human Systems and Outcomes, Inc. The case pattern archetypes were developed based on in-depth reviews of hundreds of active cases from frontline child welfare workers in a dozen states across the nation over the past decade. General patterns emerged related to four domains:

- Limited caregiver capacity or functioning
- Extraordinary caregiving demands
- Stressors, conditions, or disruptive life events
- Strengths, qualities, supports, and resources that enhance caregiver capacity and family functioning

This analysis included development of a review methodology, analysis of the case reviews by domain, and consideration of patterns most pertinent to chronic neglect cases within each domain.

Methodology

The 35 cases were cases that were reviewed during a quality service review monitoring process. A checklist was created utilizing the familial patterns within each domain of the *Case Pattern Archetypes in Child Welfare Practice*. Each case was reviewed by a research

investigator with extensive expertise and experience in early childhood systems. Familial patterns were identified using the checklist.

Reliability of the application of the case patterns to the cases was assessed by the random selection of five cases for joint review by the first research investigator and a second research investigator with extensive expertise and experience in the child welfare field. Of the 44 items rated across each of the five cases, agreement was reached on all but two items resulting in a reliability correlation of 99 percent. The high degree of agreement between the two raters is evidence of the efficacy of the tool.

Findings by Domain

As noted above, case patterns were assessed in four domains. These included limitations to caregiver capacity and functioning, extraordinary caregiving demands associated with children or family members, patterns associated with environmental factors and characteristics, and patterns associated with family strengths and resources. Appendix A includes a checklist of the familial patterns by case.

Limited Caregiver Capacity and Functioning

Table 1 provides frequency counts for the appearance of familial patterns related to limited caregiver capacity and functioning. Results reveal that addictions; absence from the home; and engagement in violent, abusive, or sexually predatory behavior are the most common caregiver capacity limitations among chronic neglect cases. Engagement in illegal activities, mental illness, and family members with extreme needs also occurred in four or more cases.

Extraordinary Caregiving Demands

Frequency counts relative to extraordinary caregiving demands are included in Table 2. A child or children with ADHD, conduct disorder, learning disability, or OD behaviors; extraordinary emotional or behavioral care needs; attachment or stress disorders; or a youth that breaks the law or poses a risk to community safety were the most frequent patterns in this domain. Youth with an addiction or serious substance abuse problem and a child assuming caregiving responsibilities were also patterns that emerged in four or more cases.

Stressors or Disruptive Life Events

Common stressors or disruptive life events among the Iowa cases included changes within the primary support group, educational problems, involvement with the legal system, discord with key supporters, and problems related to the social environment (e.g., inadequate social supports, death or loss of key supporters). In addition, occupational problems, inadequate housing, and inadequate access to health care were concerns in five or more cases. Table 3 provides frequency counts for all of the indicators in this domain.

Strengths and Resources

The final domain among the case archetypes includes strengths and resources. Table 4 provides frequency counts of the indicators in this domain. A stable, capable, and helpful primary support group was common among the cases. This support group might include parent(s), extended family, caseworkers, school personnel, other community organization staff, and/or foster parents. Adaptive abilities and good health were also present in

seven cases. It is important to note that case notes infrequently included an assessment of strengths and resources.

Conclusions

The analysis based on the archetypes underscored the role of parental substance abuse, mental illness, and domestic violence in cases of chronic neglect in Iowa. Lack of social supports and economic challenges were also significant factors. In addition, the extraordinary behavioral, developmental, social, and emotional needs of children were evident in chronic neglect cases. In most cases, there are stable, capable, and helpful primary support networks available to work on successful case closure. It was also found that few strengths and resources were identified, other than stable adults, in the case files, suggesting a tendency to consider the case from a deficit model rather than a strengths-based approach.

Part 3: Analysis of Interviews with Iowa Child Welfare Staff

A third analysis was completed to assess the experiences of child welfare professionals in terms of chronic neglect in Iowa. Seven employees of the Iowa Department of Human Services were interviewed. Table 5 provides a summary of questions and responses. Iowa child welfare professionals agreed that there is currently no defined protocol for handling cases of chronic neglect. Differences in their definitions of chronic neglect also underscored the need for a common understanding of chronic neglect. Their assessment of factors associated with chronic neglect mirrored research findings. They reported that practice strategies and responses focus on providing parenting education and household assistance. Most agreed that there is little time and

effort expended on finding underlying causes of chronic neglect and solutions and services to address those causes.

Part 4. Recommendations

Recognizing Chronic Neglect

Based on the analysis of research literature, case histories, and interviews with child welfare professionals, the following indicators emerged as pertinent to classifying a repeat case as chronic neglect. If the case is a repeat maltreatment and one or more of the following risk factors are present, classification of the case as chronic neglect should be considered.

- Child with developmental delays
- Child with severe behavior problems
- Very low income
- Few perceived and/or actual sources of informal and formal support
- Substance abuse
- Adult with mental illness
- Adult with cognitive deficit
- Domestic violence
- Young parents
- Single parent
- Large family
- High risk neighborhood

Practice Decision Making and Guidelines

Based on the three analyses completed for this project, case planning and responses should be differential for chronic neglect cases. In order to maximize success for the family, minimize risks for the child, and balance family-centered practice with any need for protective authority, caseworkers need to provide comprehensive and ongoing family assessment, convene and utilize family team planning and decision making, and

begin concurrent planning as soon as cases are identified as chronic neglect. Additional practice strategies recommended include integrated service delivery (including substance abuse, mental health, domestic violence, and early childhood services as needed), support network building, and safety and relapse planning. The pathway to permanency for children of chronic neglect requires a deliberate plan of action.

Conclusion

Special attention needs to be directed to cases of chronic neglect. Chronic neglect cases are very costly to individuals and communities, and they do not receive the research, policy, or service attention and resources that are needed. Although significant resources are required to help families, and interventions require intensive, comprehensive, and long-term commitments and services, successful resolution of such cases are possible and the long-term savings are substantial.

As evidence of the potential of attending to chronic neglect cases, ten child neglect demonstration projects were funded during 1996 and 1997 by the Children's Bureau. Direct services most often provided included: parent education (9), home visits (9), links to community resources (8), parent support (8), mental health services (6), concrete assistance (6), and crisis intervention (6). All programs reported positive outcomes, and six programs used evaluation designs that included a comparison group, pre/post use of standardized instruments, and statistical analysis of data. Outcomes included reductions in child behavior problems, parent/caregiver depressive symptoms, drug use, life stress, parenting stress, emotional problems, perceptions of child behavior problems, social isolation, foster care placement, and CPS reports. Improvements in child health, devel-

opmental adaptation, and well-being; parenting skills; and family housing and health care were also realized.

Child neglect is the predominant form of child maltreatment, and services to address the effects of chronic neglect cost communities and the state substantially in the short and long term. There is growing evidence that agencies should respond as quickly and intensively to neglect allegations as they do to physical and sexual abuse allegations. Developing a systematic approach to responding to chronic neglect can serve to improve outcomes for children and families and improve long-term well-being for all of Iowa's citizens.